Headache Assessment

Instructions

This questionnaire was designed to help you describe and communicate the way you feel and what you cannot do because of your headaches. To complete, please circle one answer for each question.

Never	Rarely	Sometimes	Very Often	Always
1	2	3	4	5

1. When you have headaches, how often is the pain severe?

   1 2 3 4 5

2. How often do headaches limit your ability to do usual daily activities including household work, work, school or social activities?

   1 2 3 4 5

3. When you have a headache, how often do you wish you could lie down?

   1 2 3 4 5

4. In the past 4 weeks, how often have you felt too tired to do work on daily activities because of your headaches?

   1 2 3 4 5

5. In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

   1 2 3 4 5

6. In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

   1 2 3 4 5

Reference: Kosinski et al. (2003). A six-item short-form survey for measuring headache impact: the HIT-6. Qual Life Res, 12, 963-974.

Clinician Notes

ID:

Date:

Follow Up:

_____

4-Week Follow Up

1.) 1 2 3 4 5

2.) 1 2 3 4 5

3.) 1 2 3 4 5

4.) 1 2 3 4 5

5.) 1 2 3 4 5

6.) 1 2 3 4 5

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*Part of the **Team Up to Facilitate Functioning (TUFF)** series by the Michael E. DeBakey VA Medical Center Polytrauma Team*